The following sections of the California Health Policy and Data Advisory Commission and the Technical Advisory Committee as follows:

127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Commencing in calendar year 2004, every freestanding ambulatory surgery clinic as defined in Section 128700, shall each year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation made in the annual Budget Act or another statute to pay for the functions required to be performed by the office ~~and the California Health Policy and Data Advisory Commission~~ pursuant to this chapter, Article 2 (commencing with Section 127340) of Chapter 2, or Chapter 1 (commencing with Section 128675) of Part 5, and to pay for any other health-related programs administered by the office. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents ($0.50).

(2) (A) For the calendar year 2004 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2004 and shall report that number to the office by March 12, 2004. The estimate shall be as accurate as possible. The fee in the calendar year 2004 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents ($0.50) and shall be due on July 1 and delinquent on July 31, 2004.

(B) The office shall compare the actual number of records filed by each freestanding clinic for the calendar year 2004 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the office shall reduce the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50). If the actual number reported exceeds the estimated number reported, the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents ($0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar ($1).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office ~~and the commission~~ in succeeding years when appropriated by the Legislature in the annual Budget Act or another statute, for expenditure under the provisions of this chapter, Article 2 (commencing with Section 127340) of Chapter 2, and Chapter 1 (commencing with Section 128675) of Part 5, or for any other health-related programs administered by the office, and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

128680. The Legislature hereby finds and declares that:

(a) Significant changes have taken place in recent years in the health care marketplace and in the manner of reimbursement to health facilities by government and private third-party payers for the services they provide.

(b) These changes have permitted the state to reevaluate the need for, and the manner of data collection from health facilities by the various state agencies and commissions.

(c) It is the intent of the Legislature that as a result of this reevaluation that the data collection function be consolidated in a single state agency. It is the further intent of the Legislature that the single state agency only collect that data from health facilities that are essential. The data should be collected, to the extent practical on consolidated, multipurpose report forms for use by all state agencies.

(d) It is the further intent of the Legislature to eliminate the California Health Facilities Commission, ~~and~~ the State Advisory Health Council, and the California Health Policy and Data Advisory Commission, and to ~~create a single advisory commission to assume~~ consolidate~~d~~ data collection and planning functions within the office.

(e) It is the Legislature's further intent that the review of the data that the state collects be an ongoing function. The office~~, with the advice of the advisory commission,~~ shall annually review this data for need and shall revise, add, or delete items as necessary. The ~~commission and the~~ office shall consult with affected state agencies and the affected industry when adding or eliminating data items. However, the office shall neither add nor delete data items to the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or judicial decision.

(f) The Legislature recognizes that the authority for the California Health Facilities Commission is scheduled to expire January 1, 1986. It is the intent of the Legislature, by the enactment of this chapter, to continue

the uniform system of accounting and reporting established by the commission and required for use by health facilities. It is also the intent of the Legislature to continue an appropriate, cost-disclosure program.

~~128695. There is hereby created the California Health Policy and Data Advisory Commission to be composed of 13 members. The Governor shall appoint nine members, one of whom shall be a hospital chief executive officer, one of whom shall be a chief executive officer of a hospital serving a disproportionate share of low-income patients, one of whom shall be a long-term care facility chief executive officer, one of whom shall be a freestanding ambulatory surgery clinic chief executive officer, one of whom shall be a representative of the health insurance industry involved in establishing premiums or underwriting, one of whom shall be a representative of a group prepayment health care service plan, one of whom shall be a representative of a business coalition concerned with health, and two of whom shall be general members. The Speaker of the Assembly shall appoint two members, one of whom shall be a physician and surgeon and one of whom shall be a general member. The Senate Rules Committee shall appoint two members, one of whom shall be a representative of a labor coalition concerned with health, and one of whom shall be a general member.~~

~~The Governor shall designate a member to serve as chairperson for a two-year term. No member may serve more than two, two-year terms as chairperson. All appointments shall be for four-year terms. No individual shall serve more than two, four-year terms.~~

128700. As used in this chapter, the following terms mean:

(a) "Ambulatory surgery procedures" mean those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic.

(b) ~~"Commission" means the California Health Policy and Data Advisory Commission.~~

~~(c)~~ "Emergency department" means, in a hospital licensed to provide emergency medical services, the location in which those services are provided.

(~~d~~c) "Encounter" means a face-to-face contact between a patient and the provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient.

(~~e~~d) "Freestanding ambulatory surgery clinic" means a surgical clinic that is licensed by the state under paragraph (1) of subdivision (b) of Section 1204.

(~~f~~e) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(~~g~~f) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.

(~~h~~g) "Office" means the Office of Statewide Health Planning and Development.

(~~i~~h) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures that have been adjusted for demographic and clinical factors.

128705. On and after January 1, 1986, any reference in this code to the Advisory Health Council ~~shall be deemed a reference~~ or to the California Health Policy and Data Advisory Commission shall be deemed a reference to the office.

~~128710. The California Health Policy and Data Advisory Commission shall meet at least once every two months, or more often if necessary to fulfill its duties.~~

~~128715. The members of the commission shall receive per diem of one hundred dollars ($100) for each day actually spent in the discharge of official duties and shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the commission.~~

~~128720. The commission may appoint an executive secretary subject to approval by the Secretary of Health and Welfare. The office shall provide other staff to the commission as the office and the commission deem necessary.~~

~~128725. The functions and duties of the commission shall include the following:~~

~~(a) Advise the office on the implementation of the new, consolidated data system.~~

~~(b) Advise the office regarding the ongoing need to collect and report health facility data and other provider data.~~

~~(c) Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.~~

~~(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.~~

~~(e) Conduct public meetings for the purposes of obtaining input from health facilities, other providers, data users, and the general public regarding this chapter and Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.~~

~~(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.~~

~~(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.~~

~~(h) Advise the office on the format of individual health facility or other provider data reports and on any technical and procedural issues necessary to implement this part.~~

~~(i) Advise the office on the formulation of general policies which shall advance the purposes of Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.~~

~~(j) Recommend, in consultation with a 12-member technical advisory committee appointed by the chairperson of the commission, to the office the data elements necessary for the production of outcome reports required by Section 128745.~~

(k) (1) The technical advisory committee appointed pursuant to subdivision (j) shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by the California Association of Hospitals and Health Systems, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical Association, two members who shall be registered nurses appointed from a list of at least six persons nominated by the California Nurses Association, one medical record practitioner who shall be appointed from a list of at least six persons nominated by the California Health Information Association, one member who shall be a representative of a hospital authorized to report as a group pursuant to subdivision (d) of Section 128760, two members who shall be representative of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, and one member representing the Consumers Union. Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee. (2) The commission shall submit its recommendation to the office regarding the first of the reports required pursuant to subdivision (a) of Section 128745 no later than January 1, 1993. The technical advisory committee shall submit its initial recommendations to the commission pursuant to subdivision (d) of Section 128750 no later than January 1, 1994. The commission, with the advice of the technical advisory committee, may periodically make additional recommendations under Sections 128745 and 128750 to the office, as appropriate.

(l) (1) Assess the value and usefulness of the reports required by Sections 127285, 128735, and 128740. On or before December 1, 1997, the commission shall submit recommendations to the office to accomplish all of the following:

(A) Eliminate redundant reporting.

(B) Eliminate collection of unnecessary data.

(C) Augment data bases as deemed valuable to enhance the quality and usefulness of data.

(D) Standardize data elements and definitions with other health data collection programs at both the state and national levels.

(E) Enable linkage with, and utilization of, existing data sets. (F) Improve the methodology and data bases used for quality assessment analyses, including, but not limited to, risk-adjusted outcome reports.

(G) Improve the timeliness of reporting and public disclosure.

(2) The commission shall establish a committee to implement the evaluation process. The committee shall include representatives from the health care industry, providers, consumers, payers, purchasers, and government entities, including the Department of Managed Health Care, the departments that comprise the Health and Welfare Agency, and others deemed by the commission to be appropriate to the evaluation of the data bases. The committee may establish subcommittees including technical experts.

(3) In order to ensure the timely implementation of the provisions of the legislation enacted in the 1997-98 Regular Session that amended this part, the office shall present an implementation work plan to the commission. The work plan shall clearly define goals and significant steps within specified timeframes that must be completed in order to accomplish the purposes of that legislation. The office shall make periodic progress reports based on the work plan to the commission. The commission may advise the Secretary of Health and Welfare of any significant delays in following the work plan. If the commission determines that the office is not making significant progress toward achieving the goals outlined in the work plan, the commission shall

~~notify the office and the secretary of that determination. The commission may request the office to submit a plan of correction outlining specific remedial actions and timeframes for compliance. Within 90 days of notification, the office shall submit a plan of correction to the commission.~~

~~(m) (1) As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.~~

~~(2) Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.~~

~~(3) The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.~~

128738. (a) The office~~, based upon review and recommendations of the commission and its appropriate committees,~~ shall allow and provide for, in accordance with appropriate regulations, additions or deletions to the patient level data elements listed in subdivision (g) of Section 128735, Section 128736, and Section 128737, to meet the purposes of this chapter.

(b) Prior to any additions or deletions, all of the following shall be considered:

(1) Utilization of sampling to the maximum extent possible.

(2) Feasibility of collecting data elements.

(3) Costs and benefits of collection and submission of data.

(4) Exchange of data elements as opposed to addition of data elements.

(c) The office shall add no more than a net of 15 elements to each data set over any five-year period. Elements contained in the uniform claims transaction set or uniform billing form required by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg) shall be exempt from the 15-element limit.

(d) The ~~commission and the~~ office, in order to minimize costs and administrative burdens, shall consider the total number of data elements required from hospitals and freestanding ambulatory surgery clinics, and optimize the use of common data elements.

128740. (a) Commencing with the first calendar quarter of 1992, the following summary financial and utilization data shall be reported to the office by each hospital within 45 days of the end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.
(7) Total operating expenses.
(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.
(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.
(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.
(11) Total capital expenditures.
(12) Total net fixed assets.
(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.
(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.
(15) Other operating revenue.
(16) Nonoperating revenue net of nonoperating expenses.
(b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (7), (8), (9), (10), (14), (15), and (16) of subdivision (a) on a group basis, as described in subdivision (d) of Section 128760.
(c) The office shall make available at cost, to any person, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.
(d) The office~~, with the advice of the commission,~~ shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines. This section shall become operative January 1, 1992.

128745. (a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication Date	Period Covered	Procedures and Conditions Covered
July 1993	1988-90	3
July 1994	1989-91	6
July 1995	1990-92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.
(b) The procedures and conditions required to be reported under this chapter shall be divided among medical, surgical, and obstetric conditions or

procedures and shall be selected by the office~~, based on the recommendations of the commission and the advice of the technical advisory committee set forth in subdivision (j) of Section 128725~~. The office shall publish the risk-adjusted outcome reports for surgical procedures by individual hospital and individual surgeon unless the office in consultation with ~~the technical advisory committee and~~ medical specialists in the relevant area of practice determines that it is not appropriate to report by individual surgeon. The office, in consultation with the ~~technical~~ clinical ~~advisory committee~~ panel established by section 128748, and medical specialists in the relevant area of practice, may decide to report nonsurgical procedures and conditions by individual physician when it is appropriate. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment. The risk adjustment report shall ensure that public hospitals and other hospitals serving primarily low-income patients are not unfairly discriminated against.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases and the seriousness of the health consequences of the procedure or condition.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) (1) In addition to any other established and pending reports, on or before July 1, 2002, the office shall publish a risk-adjusted outcome report for coronary artery bypass graft surgery by hospital for all hospitals opting to participate in the report. This report shall be updated on or before July 1, 2003.

(2) In addition to any other established and pending reports, commencing July 1, 2004, and every year thereafter, the office shall publish risk-adjusted outcome reports for coronary artery bypass graft surgery for all coronary artery bypass graft surgeries performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and cardiac surgeon. Upon the recommendation of the ~~technical~~ clinical ~~advisory committee~~ panel established by section 128748 based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

(3) Unless otherwise recommended by the clinical panel established by Section 128748, the office shall collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Mortality Reporting Program. Upon recommendation of the clinical panel, the office may add any clinical data elements included in the Society of Thoracic Surgeons' database. Prior to any additions from the Society of Thoracic Surgeons' database, the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Exchange of data elements as opposed to addition of data elements.

(4) Upon recommendation of the clinical panel, the office may add, delete, or revise clinical data elements, but shall add no more than a net of six elements not included in the Society of Thoracic Surgeons' database, to the data set over any five-year period. Prior to any additions or deletions, all of the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Feasibility of collecting data elements.

(C) Costs and benefits of collection and submission of data.

(D) Exchange of data elements as opposed to addition of data elements.

(5) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the coronary artery bypass graft report.

(6) Patient medical record numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(d) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings for each hospital:

(1) "Much higher than average outcomes," for hospitals with risk-adjusted outcomes much higher than the norm.

(2) "Higher than average outcomes," for hospitals with risk-adjusted outcomes higher than the norm.

(3) "Average outcomes," for hospitals with average risk-adjusted outcomes.

(4) "Lower than average outcomes," for hospitals with risk-adjusted outcomes lower than the norm.

(5) "Much lower than average outcomes," for hospitals with risk-adjusted outcomes much lower than the norm.

(e) For coronary artery bypass graft surgery reports and any other outcome reports for which auditing is appropriate, the office shall conduct periodic auditing of data at hospitals.

(f) The office shall publish in the annual reports required under this section the risk-adjusted mortality rate for each hospital and for those reports that include physician reporting, for each physician.

(g) The office shall either include in the annual reports required under this section, or make separately available at cost to any person requesting it, risk-adjusted outcomes data assessing the statistical significance of hospital or physician data at each of the following three levels: 99-percent confidence level (0.01 p-value), 95-percent confidence level (0.05 p-value), and 90-percent confidence level (0.10 p-value). The office shall include any other analysis or comparisons of the data in the annual reports required under this section that the office deems appropriate to further the purposes of this chapter.

128750. (a) Prior to the public release of the annual outcome reports, the office shall furnish a preliminary report to each hospital that is included in the report. The office shall allow the hospital and chief of staff 60 days to review the outcome scores and compare the scores to other California hospitals. A hospital or its chief of staff that believes that the risk-adjusted outcomes do not accurately reflect the quality of care provided by the hospital may submit a statement to the office, within the 60 days, explaining why the outcomes do not accurately reflect the quality of care provided by the hospital. The statement shall be included in an appendix to the public report, and a notation that the hospital or its chief of staff has submitted a statement shall be displayed wherever the report presents outcome scores for the hospital.

(b) (1) Prior to the public release of any outcome report that includes data by a physician, the office shall furnish a preliminary report to each physician that is included in the report. The office shall allow the physician 30 days from the date the office sends the report to the physician to review the outcome scores and compare the scores to other California physicians. A physician who believes that the risk-adjusted outcome does not accurately reflect the quality of care provided by the physician may submit a

statement to the office within the 30 days, explaining why the outcomes do not accurately reflect the quality of care provided by the physician.

(2) The office shall promptly review the physician's statement and shall respond to the physician with one of the following conclusions:

(A) The physician's statement reveals a flaw in the accuracy of the reported data relating to the physician that materially diminishes the validity of the report. If this finding is made, the data for that physician shall not be included in the report until the flaw in the physician's data is corrected.

(B) The physician's statement reveals a flaw in the risk-adjustment model that materially diminishes the value of the report for all physicians. If this finding is made, the report using that risk-adjustment model shall not be issued until the flaw is corrected.

(C) The physician's statement does not reveal a flaw in either the accuracy of the reported data relating to the physician or the risk-adjustment model in which case the report shall be used, unless the physician chooses to use the procedure set forth in paragraph (3).

(3) If a physician is not satisfied with the conclusion reached by the office, the physician shall notify the office of that fact. Upon receipt of the notice, the office shall forward the physician's statement to the appropriate clinical panel appointed pursuant to Section 128748. The office shall forward the physician's statement with any information identifying the physician or the physician's hospital redacted, or shall adopt other means to ensure the physician's identity is not revealed to the panel. The clinical panel shall promptly review the physician statement and the conclusion of the office and shall respond by either upholding the conclusion or reaching one of the other conclusions set forth in this subdivision. The panel decision shall be the final determination regarding the physician's statement. The process set forth in this subdivision shall be completed within 60 days from the date the office sends the report to each physician included in the report. If a decision by either the office or the clinical panel cannot be reached within the 60-day period, then the outcome report may be issued but shall not include data for the physician submitting the statement.

(c) The office shall, in addition to public reports, provide hospitals and the chiefs of staff of the medical staffs with a report containing additional detailed information derived from data summarized in the public outcome reports as an aid to internal quality assurance.

(d) If, pursuant to the recommendations of the office, ~~based on the advice of the commission, in response to the recommendations of the technical advisory committee made pursuant to subdivision (d) of this section,~~ the Legislature subsequently amends Section 128735 to authorize the collection of additional discharge data elements, then the outcome reports for conditions and procedures for which sufficient data is not available from the current abstract record will be produced following the collection and analysis of the additional data elements.

(e) The recommendations of the ~~technical advisory committee~~ office for the addition of data elements to the discharge abstract should take into consideration the technical feasibility of developing reliable risk-adjustment factors for additional procedures and conditions as determined by the ~~technical advisory committee~~ office with the advice of the research community, physicians and surgeons, hospitals, consumer or patient advocacy groups, and medical records personnel.

(f) The ~~technical advisory committee~~ office at a minimum shall identify a limited set of core clinical data elements to be collected for all of the added procedures and conditions and unique clinical variables necessary for risk adjustment of specific conditions and procedures selected for the outcomes report program. In addition, the committee should give careful

consideration to the costs associated with the additional data collection and the value of the specific information to be collected.

(g) The ~~technical advisory committee~~ office shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

128760. (a) On and after January 1, 1986, those systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities but shall be maintained by the office ~~with the advice of the Health Policy and Data Advisory Commission~~.

(b) The office~~, with the advice of the commission,~~ shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this chapter if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) Modifications to discharge data reporting requirements. The office~~, with the advice of the commission,~~ shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) Modifications to emergency care data reporting requirements. The office~~, with the advice of the commission,~~ shall allow and provide, in accordance with appropriate regulations, for modifications to emergency care data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) Modifications to ambulatory surgery data reporting requirements. The office~~, with the advice of the commission,~~ shall allow and provide, in accordance with appropriate regulations, for modifications to ambulatory surgery data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not be construed to permit the office to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

(f) Reporting provisions for health facilities. The office~~, with the advice of the commission,~~ shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner that is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of

a coordinated group of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.

(g) Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 128735. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.

(h) The office~~, with the advice of the commission,~~ shall adopt comparable modifications to the financial reporting requirements of this chapter for county hospital systems consistent with the purposes of this chapter.

128765. (a) The office~~, with the advice of the commission,~~ shall maintain a file of all the reports filed under this chapter at its Sacramento office. Subject to any rules the office~~, with the advice of the commission,~~ may prescribe, these reports shall be produced and made available for inspection upon the demand of any person, and shall also be posted on its Web site, with the exception of discharge and encounter data that shall be available for public inspection unless the office determines, pursuant to applicable law, that an individual patient's rights of confidentiality would be violated.

(b) The reports published pursuant to Section 128745 shall include an executive summary, written in plain English to the maximum extent practicable, that shall include, but not be limited to, a discussion of findings, conclusions, and trends concerning the overall quality of medical outcomes, including a comparison to reports from prior years, for the procedure or condition studied by the report. The office shall disseminate the reports as widely as practical to interested parties, including, but not limited to, hospitals, providers, the media, purchasers of health care, consumer or patient advocacy groups, and individual consumers. The reports shall be posted on the office's Internet Web site.

(c) Copies certified by the office as being true and correct copies of reports properly filed with the office pursuant to this chapter, together with summaries, compilations, or supplementary reports prepared by the office, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local governmental agency, board, or commission that participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal health care program. Each of these state, county, or local governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to the provisions of this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(d) The office~~, with the advice of the commission,~~ shall compile and publish summaries of individual facility and aggregate data that do not contain patient-specific information for the purpose of public disclosure. The summaries shall be posted on the office's Internet Web site. ~~The commission shall approve the policies and procedures relative to the manner of data disclosure to the public.~~ The office~~, with the advice of the commission,~~ may initiate and conduct studies as it determines will advance the purposes of this chapter.

(e) In order to assure that accurate and timely data are available to the public in useful formats, the office shall establish a public liaison function. The public liaison shall provide technical assistance to the

general public on the uses and applications of individual and aggregate health facility data and shall provide the director ~~and the commission~~ with an annual report on changes that can be made to improve the public's access to data.

128770. (a) Any health facility or freestanding ambulatory surgery clinic that does not file any report as required by this chapter with the office is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the office~~, with the advice of the commission~~.

(b) Any health facility that does not use an approved system of accounting pursuant to the provisions of this chapter for purposes of submitting financial and statistical reports as required by this chapter shall be liable for a civil penalty of not more than five thousand dollars ($5,000).

(c) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the office. Assessment of a civil penalty may, at the request of any health facility or freestanding ambulatory surgery clinic, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(d) Any money that is received by the office pursuant to this section shall be paid into the General Fund.

128775. (a) Any health facility or freestanding ambulatory surgery clinic affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within a greater time as the office~~, with the advice of the commission,~~ may allow, and shall specifically describe the matters which are disputed by the petitioner.

(b) A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the office, or an administrative law judge employed by the Office of Administrative Hearings~~, or a committee of the commission chosen by the chairperson for this purpose~~. If held before an employee of the ~~office or a committee of the commission~~, the hearing shall be held in accordance with any procedures as the office~~, with the advice of the commission,~~ shall prescribe. If held before an administrative law judge employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The employee~~,~~ or administrative law judge~~, or committee~~ shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(c) Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the office shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

(d) The employee of the office, the administrative law judge employed by the Office of Administrative Hearings, or the Office of Administrative Hearings~~, or the committee of the commission~~ may issue subpoenas and

subpoenas duces tecum in a manner and subject to the conditions established by Article 11 (commencing with Section 11450.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) This section shall become operative on July 1, 1997.

128785. On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission that relate to functions vested in the office and that are in effect on that date, shall remain in effect and shall be fully enforceable to the extent that they are consistent with this chapter, as determined by the office, unless and until readopted, amended, or repealed by the office ~~following review and comment by the commission~~.

128810. The office shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein. ~~The commission shall advise and consult with the office in carrying out the administration of this chapter.~~

129010. Unless the context otherwise requires, the definitions in this section govern the construction of this chapter and of Section 32127.2.

(a) "Bondholder" means the legal owner of a bond or other evidence of indebtedness issued by a political subdivision or a nonprofit corporation.

(b) "Borrower" means a political subdivision or nonprofit corporation that has secured or intends to secure a loan for the construction of a health facility.

(c) "Construction, improvement, or expansion" or "construction, improvement, and expansion" includes construction of new buildings, expansion, modernization, renovation, remodeling and alteration of existing buildings, acquisition of existing buildings or health facilities, and initial or additional equipping of any of these buildings.

In connection therewith, "construction, improvement, or expansion" or "construction, improvement, and expansion" includes the cost of construction or acquisition of all structures, including parking facilities, real or personal property, rights, rights-of-way, the cost of demolishing or removing any buildings or structures on land so acquired, including the cost of acquiring any land where the buildings or structures may be moved, the cost of all machinery and equipment, financing charges, interest (prior to, during and for a period after completion of the construction), provisions for working capital, reserves for principal and interest and for extensions, enlargements, additions, replacements, renovations and improvements, cost of engineering, financial and legal services, plans, specifications, studies, surveys, estimates of cost and of revenues, administrative expenses, expenses necessary or incident to determining the feasibility or practicability of constructing or incident to the construction; or the financing of the construction or acquisition.

(d) ~~"Commission" means the California Health Policy and Data Advisory Commission.~~

~~(e)~~ "Committee" means the Advisory Loan Insurance Committee.

(~~f~~e) "Debenture" means any form of written evidence of indebtedness issued by the State Treasurer pursuant to this chapter, as authorized by Section 4 of Article XVI of the California Constitution.

(~~g~~f) "Fund" means the Health Facility Construction Loan Insurance Fund.

(~~h~~g) "Health facility" means any facility providing or designed to provide services for the acute, convalescent, and chronically ill and impaired,

including, but not limited to, public health centers, community mental health centers, facilities for the developmentally disabled, nonprofit community care facilities that provide care, habilitation, rehabilitation or treatment to developmentally disabled persons, facilities for the treatment of chemical dependency, including a community care facility, licensed pursuant to Chapter 3 (commencing with Section 1500) of Division 2, a clinic, as defined pursuant to Chapter 1 (commencing with Section 1200) of Division 2, an alcoholism recovery facility, defined pursuant to former Section 11834.11, and a structure located adjacent or attached to another type of health facility and that is used for storage of materials used in the treatment of chemical dependency, and general tuberculosis, mental, and other types of hospitals and related facilities, such as laboratories, outpatient departments, extended care, nurses' home and training facilities, offices and central service facilities operated in connection with hospitals, diagnostic or treatment centers, extended care facilities, nursing homes, and rehabilitation facilities. "Health facility" also means an adult day health center and a multilevel facility. Except for facilities for the developmentally disabled, facilities for the treatment of chemical dependency, or a multilevel facility, or as otherwise provided in this subdivision, "health facility" does not include any institution furnishing primarily domiciliary care.

"Health facility" also means accredited nonprofit work activity programs as defined in subdivision (e) of Section 19352 and Section 19355 of the Welfare and Institutions Code, and nonprofit community care facilities as defined in Section 1502, excluding foster family homes, foster family agencies, adoption agencies, and residential care facilities for the elderly.

Unless the context dictates otherwise, "health facility" includes a political subdivision of the state or nonprofit corporation that operates a facility included within the definition set forth in this subdivision.

(~~i~~h) "Office" means the Office of Statewide Health Planning and Development.

(~~j~~i) "Lender" means the provider of a loan and its successors and assigns.

(~~k~~j) "Loan" means money or credit advanced for the costs of construction or expansion of the health facility, and includes both initial loans and loans secured upon refinancing and may include both interim, or short-term loans, and long-term loans. A duly authorized bond or bond issue, or an installment sale agreement, may constitute a "loan."

(~~l~~k) "Maturity date" means the date that the loan indebtedness would be extinguished if paid in accordance with periodic payments provided for by the terms of the loan.

(~~m~~l) "Mortgage" means a first mortgage on real estate. "Mortgage" includes a first deed of trust.

(~~n~~m) "Mortgagee" includes a lender whose loan is secured by a mortgage. "Mortgagee" includes a beneficiary of a deed of trust.

(~~o~~n) "Mortgagor" includes a borrower, a loan to whom is secured by a mortgage, and the trustor of a deed of trust.

(~~p~~o) "Nonprofit corporation" means any corporation formed under or subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 1 of the Corporations Code) that is organized for the purpose of owning and operating a health facility and that also meets the requirements of Section 501(c)(3) of the Internal Revenue Code.

(~~q~~p) "Political subdivision" means any city, county, joint powers entity, local hospital district, or the California Health Facilities Authority.

(~~r~~q) "Project property" means the real property where the health facility is, or is to be, constructed, improved, or expanded, and also means the health facility and the initial equipment in that health facility.

(~~r~~r) "Public health facility" means any health facility that is or will be constructed for and operated and maintained by any city, county, or local hospital district.

(~~t~~s) "Adult day health center" means a facility defined under subdivision (b) of Section 1570.7, that provides adult day health care, as defined under subdivision (a) of Section 1570.7.

(~~u~~t) "Multilevel facility" means an institutional arrangement where a residential facility for the elderly is operated as a part of, or in conjunction with, an intermediate care facility, a skilled nursing facility, or a general acute care hospital. "Elderly," for the purposes of this subdivision, means a person 60 years of age or older.

(~~v~~u) "State plan" means the plan described in Section 129020.

129015. The office shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein. ~~The commission, as authorized by this chapter and by Section 129460, shall advise and consult with the office in carrying out the administration of this chapter.~~

129100. Every applicant for insurance shall be afforded an opportunity for a fair hearing before the ~~commission~~ committee upon 10 days' written notice to the applicant. If the office, after affording reasonable opportunity for development and presentation of the application and after receiving the advice of the ~~commission~~ committee, finds that an application complies with the requirements of this article and of Section 129020 and is otherwise in conformity with the state plan, it may approve the application for insurance. The office shall consider and approve applications in the order of relative need set forth in the state plan in accordance with Section 129020. Judicial review of a final decision made under this section may be had by filing a petition for writ of mandate. Any petition shall be filed within 30 days after the date of the final decision of the office.